

Annual Oration: Royal Victoria Hospital

## Membership by examination

S D Roberts

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This is the 167th annual oration. However well one may have prepared, there remains an uneasy feeling, generated from not one, but 166 previous orations, and by the highly discriminating audience present, which contains former as well as future orators.

For an individual, it would certainly encourage humility to measure one's self up against the majesty of the whole of creation. Most find it more practical to relate to groups of about this size. By so reducing the scale of the reference group it is easier to find a place somewhere in it. We can begin to recognise ourselves in comparisons with others, and are in turn recognised by others for what we are. It is comfortable to operate within our peer groups socially and sociably, avoiding conflicts. When disconnected we feel isolated and uneasy. "Belonging" is advantageous.

To some of these groups we do simply belong – to our family, to our race. We are incorporated without any element of choice. Others we chose to join. When we do decide to "join in" we have to agree to accept the principles and the objectives of the other members, and to allow their attitudes eventually to shape our own. "You can tell a man by the company he keeps"; "You can always tell an old Instonian, but you can't tell him much".

After taking my place within my family and amongst my generation of the human race, I embraced Christianity, though I don't actually remember being given a choice of religions. Nor do I remember being asked which primary school – public elementary school as it was then – I would prefer. The first thing I actually remember wanting to join and joining was the Cub Scouts. I also remember much later wanting to join the Staff of the Royal Victoria Hospital. So much so that we sat up all night in the East Wing to enlist as Housemen.

There are similarities between joining the Medical Staff of the Royal Victoria Hospital and joining the 57th Belfast Cub Pack. There is an examination: a medical degree in the case of the RVH and an interview; and the ability to tie a few knots and light a fire with one match in the case of the Cubs. In each case there also had to be an intention and a desire not only to join, but to participate. By becoming involved we received from each in exchange character-building experiences.

Advantages, perceived or real, gained from membership are not often given for free. There is no gain without pain. The pain may be felt only in the wallet, and putting the entry fee up can certainly be highly selective. Similarly, insecurity

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for young doctors working long hours in hospital on an uncertain training ladder can become very discouraging. That some other organizations can and do demand absolute obedience, secrecy and life-long fidelity, may just have to be accepted by those wishing to join. Membership can even exact a promise to lay down one's life, for one's country or cause. Thus the consequences of membership may be so extreme as to become the very means by which the members select themselves.

The selection procedures for those who aspire to membership are congruous with the ethics and objectives of the group to be joined. Entry by donation was used by Lloyd George and perhaps others to recruit to the Peerage those who had sufficient money rather than those with merely sufficient blue blood. Though rather sordid it was certainly not unfair, and probably did accurately reflect the ethics and objectives of both parties involved in the transactions. In contrast, discrimination purely on the grounds of prejudice (such as sexual prejudice or racial prejudice) is clearly unfair and greatly devalues both sides.

When membership carries with it professional advantages, access must either be completely open to all who would wish to join, or else, if there is a selection procedure, that must be scrupulously fair. Discrimination is a word now distorted to imply "unfair discrimination". But, as long as the standard required is explicitly defined, then a rigorous discriminatory mechanism which is reproducible, is perfectly correct. When the accolade of a professional association brings with it not only the immediate joy of achievement but also security of employment and pecuniary advantage, there is clearly a responsibility on those who set the standards for membership and then administer the selection procedures, to scrutinise those systems very carefully. To examine the examinations in fact.

The Royal Colleges have a long tradition of accepting responsibility for setting standards in medicine. My thesis is that examination to those standards is the proper pre-requisite for all seeking admission to their membership. Trials by ordeal, conquest by trial of arms, hazards of strength and skill would all be highly selective but they do tend to be rather wasteful of potential talent. Examinations must not waste potential talent either.

## **THE COLLEGE OF PHYSICIANS**

Man is a social animal. Physicians, like other men and women, cluster, for example as Colleges of Physicians, into which some aspire to enter as Members. The Colleges of Physicians emerged within the large urban communities of the 16th and 17th centuries, in Dublin as in London and Edinburgh. The function of these Colleges was to regulate the practice of the art of science of Physic.

The traditional structures in Ireland for the care of the sick, through hereditary clan physicians, having been disbanded, medical practice in the City had fallen into a deplorable state. Dublin in the first half of the 17th Century contained under 9,000 inhabitants, (not quite twice the number of staff on the RGH site), but "There appeared to be more persons in Dublin at that time practising medicine than any other art, yet very few of them had the six qualifications which Hippocrates required of a medical doctor".

It was to regulate this state of affairs that in 1692, from a Fraternity of Physicians already founded by John Sterne in 1654 to raise the standards of medicine in

Dublin, by Royal Charter of William and Mary, the Kings and Queens College of Physicians became the official body in Ireland for the regulation of Doctors.

There already was one medical corporation in Dublin for the Barber-Surgeons, which for a time included the Apothecaries and even the periwig makers. The Barbers, Surgeons and Apothecaries were the medical attendants of the poorer classes, whereas the University-educated Physician (who charged a higher fee) called upon the well-to-do. Although Physicians had a very clear perception of the limited abilities of Surgeons and Apothecaries, these worthy adversaries did not always concur. They continued to minister to the poorer classes, became in effect the General Practitioners of their day, and successfully resisted all attempts by the Physicians to neutralise them.

To set out the development of the Irish College merely as a series of dates deprives the observer of the fascination of seeing in a single institution, its evolution occurring in harmony with the social, political and intellectual changes of the time. At the time of its foundation sectarian prejudice and apprehension abounded, lest the Jacobites returned. The total number of Fellows of the College was effectively limited to 14, by requiring them to take oaths and to subscribe to a declaration which included the Oath of Allegiance and declarations denying the mass and trans-substantiation, and abjuring the spiritual supremacy of the Pope. In other words, as David Mitchell points out in his book, all the original 14 Fellows just had to be protestant loyalists. There was a wish to exclude others for various reasons, for example those outside a radius of 7 miles from Dublin, and of course Apothecaries, Barbers and Surgeons. (The byelaws in 1879 still stated "No Fellow of any College of Surgeons shall be admissible to the Fellowship of this College").

But in the course of a visitation to the College the Lord Chief Justice of Ireland gave a judgement reminiscent of that in "The Merchant of Venice". He agreed that the Physicians did have the power to reject, but argued that this was coupled with the obligation to admit, all persons who were qualified, the public having the right to the assistance of such persons. The judgement of determining the skill to practice physic remained entrusted to the College, but they were reminded that in the exercise of this trust they should be fair and not arbitrary, capricious, or biased. The mechanism of selection for admission soon to be evolved was that of the examination.

The very first examination held in the College in Dublin was on the 3 May 1693. The pass rate was 100%, the only candidate, Dr Edward Wheatenhall being successful. It must be remembered that at that time examinations for medical candidates consisted of debate-like defences of proposed theses against the President and Censors of the College who acted as their opponents during the disputation. A question-list of 1698 (below) shows that the examination would not have been any pushover for today's Membership candidates.

1. An nervi aliquid deferunt praeter spiritus animales.
2. An pulmones inflantur quia dilatantur.
3. An secretio bilis sit in hepate tantum.
4. An sanguis nutriat.
5. An dantur paricularia vasa deferentia urinam ad vensicam praeter ureteres.
6. An omne animal generatur ex ova.

Within 25 years the examinations began to lose their medieval characteristics. Recollect that the early university Doctor of Medicine graduated with knowledge only, being left to acquire any practical experience afterwards as best he could. Although the inhibitory influences limiting the number of Fellows were removed in 1761, the modern attitudes of the College of Physicians to medical education had to await the painfully slow emergence of medical practice from a theoretical obsession with symptoms (plus a little basic science) to the full acceptance of the need to teach clinical skills and the physical examination of patients as cornerstones of the modern practice of internal medicine.

Clinical teaching was adopted in Dublin following the system in use in Edinburgh which in turn had been based on the practice of Leiden University. In the 18th century Leiden had become the greatest clinical centre in Europe and her Edinburgh pupils raised their University to similar heights. Dublin's inspiration came directly from Edinburgh. John Cheyne, an Edinburgh graduate, came to Dublin as an army surgeon. By 1880 the examination for Membership of the College of Physicians included clinical as well as theoretical and scientific topics. The golden age of Irish medicine made Dublin a leading teaching centre, with emphasis on bedside clinical teaching and pathology. Clinical teachers who became Presidents of the College include Robert Graves, and William Stokes whose statues today adorn the College with Dominic Corrigan's.

Now for the first time the new category of Membership of the College emerges, in the provisions of the 1878 supplemental Charter. New byelaws regulate that the election of Fellows is in future to be from the Membership of the College only, and the method of selection Members is to be by examinations. The scope of the examination is described in these byelaws, which also require candidates to produce, besides a testimonial as regards their moral character and professional conduct, evidence of having attended courses of practical instruction. Examinations for Membership were scheduled to take place quarterly, the examination fee being 20 guineas and refundable.

Further details of the Membership examination at that time are given in the byelaws of the College dated September 1895. These are very similar to the examinations of the present day. Examination was to be (1) by written papers, (2) clinically, and (3) orally, the duration and content of the various parts of the examinations being remarkably similar to today's. The principle was evolved of having multiple examiners working in pairs assessing each candidate. Clinical examinations were conducted in the metropolitan hospitals in the forenoon of the day following the papers "the candidates being informed of the hospital only a short time before the hour of the Examination". Candidates who passed the examination were required to attend at the College on the Friday following, to subscribe to the Declaration in the presence of the Fellows and to sign the Roll of Members.

Until 1963 the examination remained essentially unchanged since 1895. In 1963 it consisted of two parts, the first part being a written and oral examination in general medical subjects and basic science to the standard of a good pass in Final MB. The second part allowed a choice from a range of subjects: general medicine, or mid-wifery and gynaecology, pathology, or neurology and psychiatry. A paediatric option has been available in recent years. The standard of this second part of the examination was extremely high.

Between 1964 and 1970 discussions between the Royal Colleges of Physicians within the UK regarding a common membership for the UK colleges led to an agreement that the Irish College might share the Part I examination with the UK Colleges. Irish College byelaws were accordingly changed to read "MRCPI Part I shall be a multiple choice question examination set in conjunction with the Royal Colleges of Physicians of Edinburgh, Glasgow and London". The Part II examination for the MRCPI remains a distinct entity.

To qualify for entry to the Irish Part II, candidates must pass Part I MRCPI or be exempt, because they hold a qualification equivalent to a full MRCPI. This exemption is reciprocated by the UK Colleges. The bilateral insistence on a Part II standard for exemption from Part I recognises the independence of the MRCPI and the MRCP UK qualifications. The objective of both the examinations is actually the same, that is to identify doctors who are ready to start higher training.

Byelaws govern the Membership examinations and changes to the byelaws can be cumbersome to effect. There is therefore a useful inertia moderating changes to the College examinations. After all, two hundred years had to pass before the Fellows finally discarded their exclusiveness, and made an examination for medical excellence the only test for entry to their ranks.

At one time it looked as if the whole MRCPI would be subsumed into the UK examination. In 1973 a notice of motion before the Fellows was "that it is in the best interest of Irish medicine that this College have a common Membership examination with the UK Colleges". The merger never took place. Dr Alan Grant, a previous President of the Irish College and an Ulsterman well-known to some members of this audience, opposed the merger on the grounds that "a distinct Irish College would do much to raise and to maintain the standards of medicine in the country". When subsequent figures showed falling numbers taking the Membership examination at the Scottish Colleges contrasting with a threefold increase in the take-up of the Membership in Dublin, the argument collapsed. At a College meeting the original motion was withdrawn and thus "the great controversy ended without a vote, but with a clear majority for the conservative position". And this position has remained ever since until the present day.

## **PERFORMANCE IN THE MEMBERSHIP EXAMINATIONS**

Information on all the current examinations is published in the Examination Regulations, and previous papers are available. Counselling of candidates is encouraged and unsuccessful candidates receive a full account of their performance and sometimes advice from the Director of Examinations. There is no longer any mystery. Permission to present this data on the MRCPI examinations has been freely given by the College, with the full co-operation of the Examinations Office, to whom I am most grateful.

Though some of you will be familiar with the MRCP examinations having sat and I hope passed, others will need some explanation. Part I of the Membership aims to test a physician's factual knowledge. Obviously this examination has to accommodate expansion in medical knowledge and new questions should alert postgraduates to developing areas of medical interest. Yet the standard must remain constant. Because applications from larger and larger numbers of

candidates also posed logistical problems, especially for the organisers of the clinical section of the examination, an MCQ was devised to filter out only those with a good chance of success in Part II. That it has been successful in this objective is shown (Fig 1) by the close correlation between success in Part I and subsequent success in Part II.

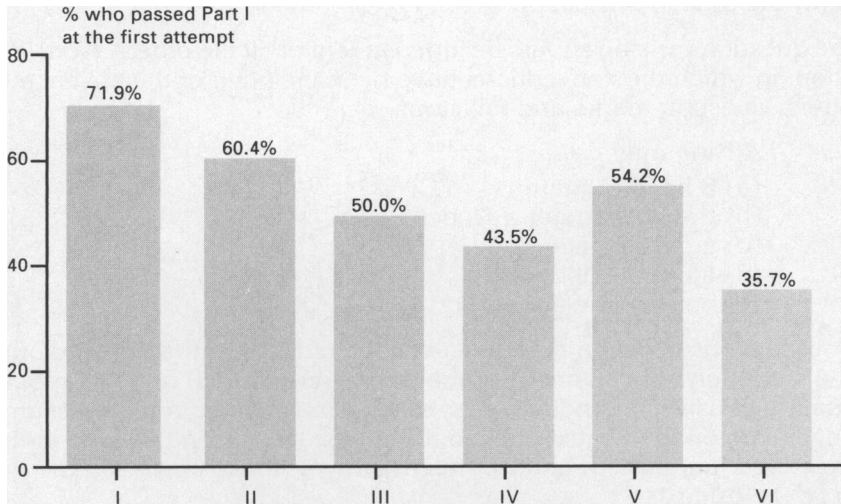


Fig 2 There is a significant ( $X^2 = 18.9$ ,  $p = 0.002$ ) correlation between performance in Part I MRCPI and performance of the same candidates in Part II. 375 candidates are grouped according to the number of attempts taken to pass Part II, and for each group the percentage who passed Part I at their first attempt has been calculated.

Properly crafted, an MCQ paper is a reliable test of factual knowledge. There are several types. The MCQ Part I paper asks the candidate to mark for each of five responses to a stem question, whether the answer is true or false. There is a 'don't know' option which scores nil. A minus mark given for an incorrect response appears to inhibit the temptation to guess, which is perhaps an attitude that should be discouraged in doctors. Great care is taken by a Board of Examiners to check that all facts are currently correct. Completed papers are automatically scanned and the candidate's answers are used to calculate not only his performance but also the discriminatory power of each single question.

There are certain problems with MCQ papers. It is possible for a candidate to improve his marks simply by practising MCQ technique. Knowing when to 'play hunches' and timing improve with familiarity. Learning the conventions of the wording employed is also important. Thus a 'characteristic' feature means it is virtually diagnostic, but a 'recognised' feature will be found in the small print. Medicine is a biological science, so 'always' and 'never' anticipate false answers; as 'may' and 'can be' signal a true. The following are illustrative of 'bad' questions:

- A King is invariably
- (a) Rich
  - (b) Wise and Good
  - (c) The Head of State

- (d) The Husband of a Queen
- (e) Usually found in a Castle

In this question 'invariably', which is the same as 'always', tells us that all the answers are false. Also 'Rich' is too vague, (b) asks a double question, and (e) does not read with the stem. By the way, by convention, 'usually' means more than 50% (of the time in this case).

Each of the questions arising should be independent of all the others. Consider this question, in which the conventions have been included of the absence of capital letters, question marks and full stops.

- A King may be
- (a) a head of State
  - (b) the husband of a Queen
  - (c) a chess piece
  - (d) all of the above
  - (e) none of the above

This is a mischievous question designed to 'catch out' rather than to 'find out'. 'May' signals strongly that all answers should be true. But (d) and (e) appear to be mutually exclusive. A candidate may quickly mark (d) as correct, assume (e) is false, and go on to the next question. But, because a King may be at the same time exiled, unmarried, and not necessarily a chess piece the correct answer to (e) is 'true'.

Question setting, like answering, takes time and trouble. To be present at a meeting of the MCQ Board of Examiners is of course an honour and a privilege but also an experience. Each question is reviewed by one designated examiner in front of a whole panel of experts in a way reminiscent of the medieval debate-like defence about which we heard earlier. Their combined sharp minds trim most of the fat off both the question and its appraiser. Besides knowledge, attention to minutiae, and exactitude in language, Part I Board members require an extra talent, which I can only describe as an 'acrostic' mentality.

A computer programme allows the final mark gained to be credited as a pass if it is equal to or greater than the numerical mark which will allow through 35% of those candidates who sat that paper in the UK.

Although Part I of the Irish examination is shared with the UK Colleges, Part II has always been slightly different. Its size and pace are different and it is completed in one week from the time of the first paper until the results are posted at the College the following Friday evening. Like other Part II examinations it includes written, oral and clinical sections, but unlike the UK examinations those who proceed to the clinical section – usually about two thirds – do so on the basis of their combined written and oral marks.

There is criticism of all Part II of the Membership examinations because they are 'elitist', elitism not being currently fashionable in Europe. The pass rate today for the complete exam remains at about 10% overall (compounding the 30% pass rates of both parts of a two part examination). This was the rate years ago when the Colleges were less ashamedly elitist. That the standard has been constant is shown if a homogenous group – the Irish candidates – is studied over the period of ten years between 1983 and 1993 (Fig 2) there being no evidence

of increasing success. In the special case of non-Irish candidates these now perform significantly better than they did 10 years ago, and account for the slightly better performance of the group as a whole over this period. By the way, there is no significant seasonal variation.

The low pass rates are responsible for a number of misconceptions amongst which is that the cases presented and the questions set are unreasonably exotic. But, though the curriculum is nowhere precisely defined, the content of the examination, because it is generated from the combined experiences of the

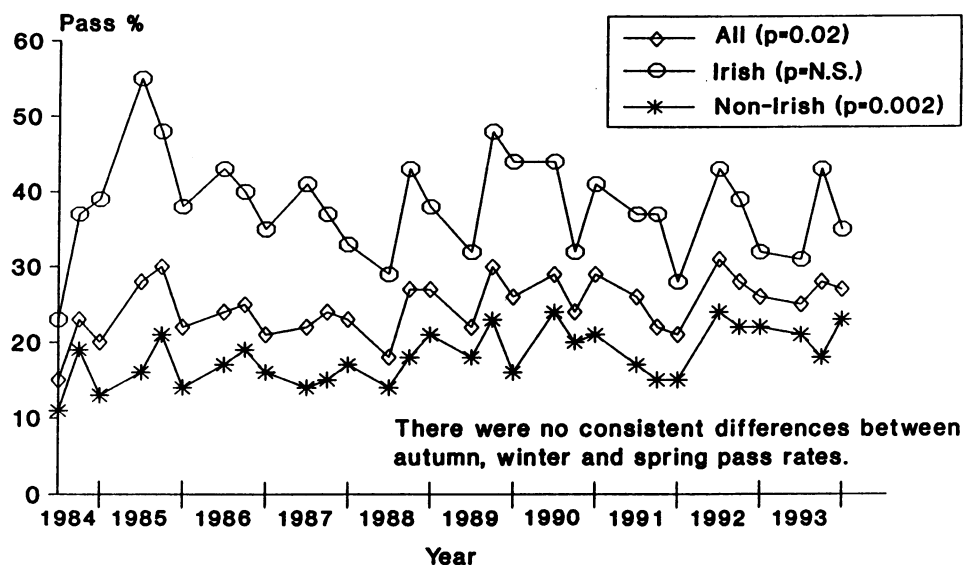


Fig 2 The pass rates (%) for 30 consecutive exams for All candidates, Irish and Non-Irish groups. The rising pass rate between 1984 and 1993 is entirely due to the improving performance of the Non-Irish group.

Panel of Examiners, must reflect the distribution and abilities of specialists as would be found in any general hospital. It is therefore easy to predict and confirm that, for example, cardiological problems will be commonly encountered. (Table).

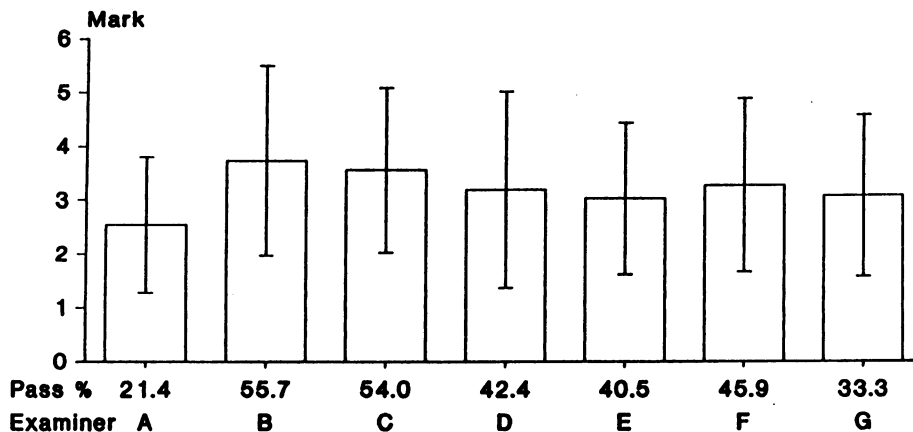
TABLE

Topics of data interpretation questions MRCPI

	%	
Diseases of heart and cardiovascular system	23	50%
Gastroenterology and hepatology	12	
Renal and electrolyte problems	11	
Clinical pharmacology and toxicology	4	
Endocrinology and metabolism	12	30%
Haematology and coagulation	10	
Respiratory medicine	8	
Neurology	9	20%
Infectious diseases	7	
Others (psychiatry, rheumatology, dermatology, multiple systems)	4	



Another misconception is that the fate of the candidate has been determined by the venomous intervention of one psychopathic examiner. Data is available on the performance of examiners in the oral section, where the encounter is one to one, and is capable of analysis. (Fig 3).



*Fig 3* The mean mark and standard deviations for each of seven examiners marking in consecutive MRCPI oral examinations.  $\chi^2$  for heterogeneity ( $\chi^2 = 32.1$ ) shows significant variability among examiners ( $p < 0.001$ ). The % of candidates who gained a pass mark or higher is given for each examiner. There was no significant trend of the mean score or range of marks awarded by any examiner to change with length of examining experience.

It is evident that the performance of different examiners differs. This is in spite of the MRCPI oral examination being structured, requiring all examiners to use the same ECGs and x-rays. Variability may occur if examiners look for something more than knowledge. Doctors who succeed must be able to think rapidly and clearly under stress. One approach has been to make examiners aware of their own performance compared to others, in the hope that perhaps this may develop conformity, rather like medical audit is supposed to. But examiners we studied did not appear to change their marking much over time. A better safe-guard for the candidate lies in the fact that no single examiner has been given the power to fail or to pass any individual. In the MRCPI, each candidate will have been assessed by a minimum of ten different examiners from a group which always includes two external, one from the Scottish Colleges and one from London. Further, a Court of Examiners meets each evening regulated by the Director, and the conformity of all the results of all the candidates is scrutinised.

Also marks may be exchanged between the main sections of the examination, so that any candidate, provided always that he has passed the clinical, can make up for shortcomings. The whole examination is rather dominated by the clinical section where high marks can have a powerful influence. But is this the most reliable section? The case material against which the candidates are tested is difficult to control. The importance of the physical examination of patients seems to be an anachronism and yet, would you be prepared to accept the advice of a doctor who couldn't take a history or use a stethoscope or feel the tumour in your abdomen? No such doctor will pass the long and the short cases of the clinical.

There is always concern about those who travel from outside these shores to test themselves against our national perceptions of desirable standards. Can we justify imposing our preconceptions upon their very different needs? The evidence is that the standards required by us of candidates from wherever they originate is indeed of value to them. Candidates come from the middle east, Africa, the Indian sub-continent and the far east as well as some from Europe. And holders of the MRCPI practice medicine successfully in all corners of the globe. That non-Irish candidates perform less well in the MRCPI compared to candidates of Irish origin does not reflect in any way on the mechanisms of the examinations. It is evident that the individuals within the Irish and the non-Irish groups are significantly different. One example is the large difference in the time interval between medical registration and application to sit Part II (Fig 4). Some similar data is available concerning candidates in paediatrics. As it was suggested that their performance in Part I may also have been prejudiced by the proportion of questions drawn from adult medicine, paediatricians have now been offered a special option.

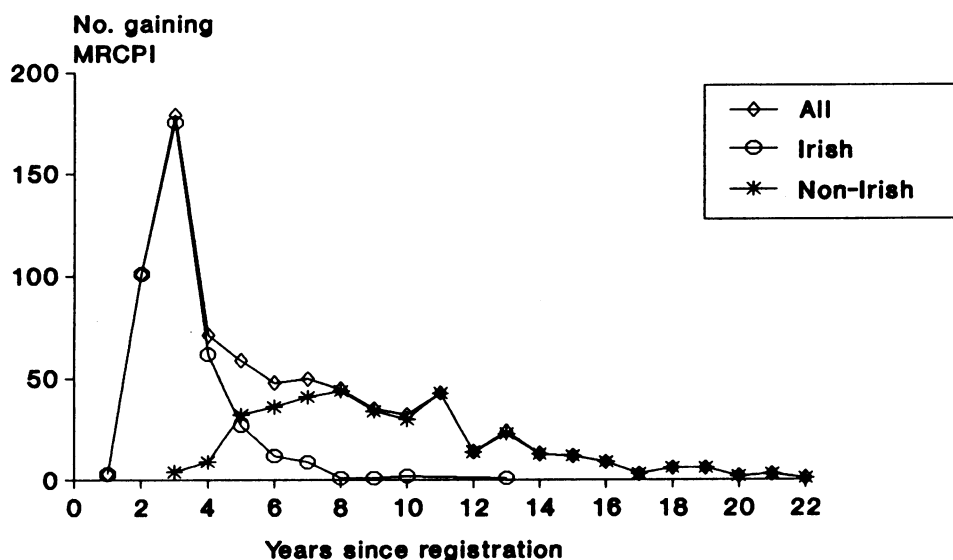


Fig 4 Years between medical registration and success in MRCPI for all candidates, and for Irish and Non-Irish groups. A comparison of mean year shows a highly significant difference ( $p < 0.0001$ ) between the groups. Note that the absolute numbers of All and Irish candidates have been scaled down x5.

Adequate preparation is important, and those who lack practical experience are exposed badly in the orals and clinicals. It is very difficult to deceive six examiners who all know the 'tricks of the trade'. Candidates who pass certainly are suitable for specialist training but data is not available to answer 'is anyone excluded by the examination who would have benefited from higher training?' I have no information regarding those who either don't complete all their attempts or who finally fail after six. Some probably do well enough for it is certainly possible to reach the pinnacles of the profession without ever having passed or indeed without ever having sat and failed the MRCPI.

In fact most candidates do pass within three years of registration, a figure that could be used to define a reasonable length for core training in medicine. At each attempt a candidate has a reasonable chance of success and for the Irish, that chance of success actually increases with more and more attempts. (Fig 5).

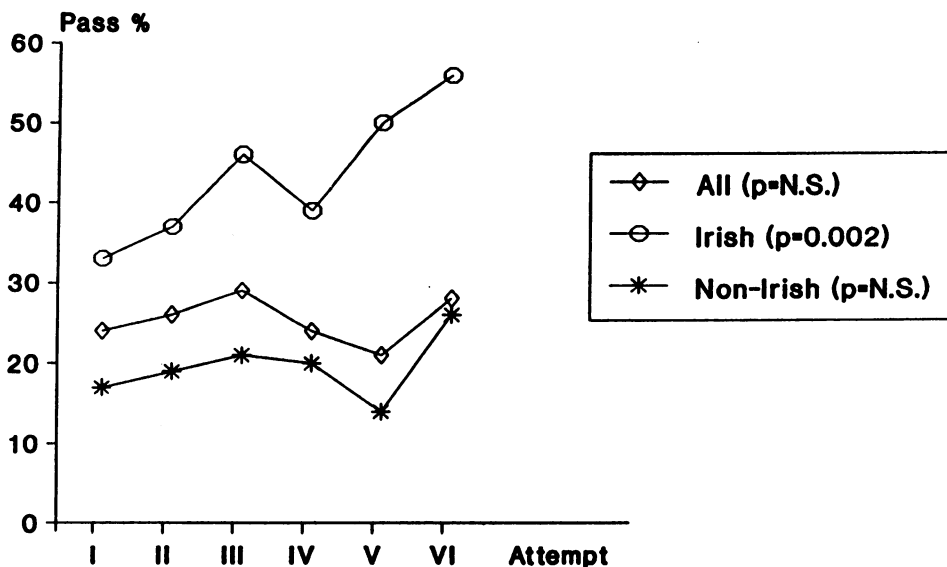


Fig 5 There was no significant difference in the pass rates in Part II for any attempt between first and sixth, save in the case of the Irish. The graphs show % pass rates.  $\chi^2$  for trend shows significantly better performance by Irish candidates in later attempts.

Candidates who do not prepare properly risk running out of attempts. There is currently an absolute maximum of six attempts allowed at the second part. It has also been a principle that a fixed limit of time should be set between success in Part I and completion of all attempts at Part II. In my own time as Director of Examinations this interval widened until by 1992 it had been extended from five years to seven years. A further amendment allows that additional attempts are possible under special circumstances even after seven years. Thus, though the standard of the examinations has not changed, accessibility to them continues to improve. One of the problems with any examination is that it can only attest to the candidate's ability on the day. But if the examination is a gold standard to be achieved, and if candidates at the 6th attempt have at least as good a chance of reaching it as at the first five, should unlimited access not be considered?

## THE FUTURE

What people do with the College's Membership certificate is their own business. Most hang it on the wall. It can be made a milestone in the process of continuing medical education. It has become a gate through which a young doctor has to pass on his way from one level of training to another. The illogicality of an examination, taken towards the end of a period of training in approved posts,

which passes only 10% of the candidates, will have to be justified. Would continuous assessments or some even lower level of achievement such as certification of attendance, be acceptable? Paediatricians have been given a special option, why not other specialties? This was offered in the past by the Edinburgh College, membership of which was available in special subjects. A higher level of membership examination could possibly function as an exit visa from specialist training. Each medical specialty now has its own specialist body, but there is no evidence so far that interactions between these organisations and the Royal Colleges are moving towards developing exit type examinations in medicine. Certification in internal medicine and its specialties seems more likely to develop as a sort of apprenticeship.

More women doctors are seeking to progress as specialists and their particular needs will have to be accommodated. Like general education, medical education will, and should continue at different levels of intensity throughout the whole of medical life. The Colleges have accepted a responsibility for CME and are well placed to deliver if required, judgements on specialist's standards and training.

Fortunately for us all these Colleges have remained totally independent voices speaking only for medicine (surgery, obstetrics, anaesthetics and so on). Their comments are based on professional considerations only. As learned professional associations they are deeply concerned about medicine and health, but in a way that all practising doctors should be. Their opinions and advice may be ignored or usurped by the latest quango, but they are available, and without charge. They represent the views of people who have dedicated themselves to achieve the highest standards of medical practice, people who have sworn an oath to maintain those standards and to maintain Hippocratic principals.

Colleges are not political but they have had to be concerned about the Nation's health, which is now regarded as the domain of the politician. Public statements are issued regularly by the Royal Colleges on health matters. Their recent expressions of very deep concern about the manipulation of a National Health Service on the basis of incomplete data are genuine. When the Colleges question the equality of access to health care for minority racial groups, for the elderly and for the poor, these questions have arisen from their statutory responsibility to maintain standards. They speak from the principles of Hippocrates rather than from a political point of view or Keynesian philosophy. Purchasers and providers may be real enough in economic terms, but the benefit of their insertion into the practice of medicine is still speculative, and can hardly be justified yet, certainly not on the basis of three or four years experience. Their potential to damage medical training and research gives rise to genuine anxiety. As scientists we would have preferred data to dogma. Set against three or four hundred years of the College's responsibility for delivering on medical standards in response to the community's expressed wishes, the 'Purchaser and Provider philosophy' will have to face the challenge of the test of time. But where will the politician be then, to answer? Time is short but the art is long and be assured that medicine as medicine is likely to survive. I would be of the opinion that it is more relevant to the survival of medical excellence that the Colleges should thrive rather than any particular politician or political dogma.

'The College' by the way, is the corporate body of its Fellows and not in fact the building. As Fellows are only capable of election if they are already Members,

and Membership being exclusively or virtually exclusively gained by examination, it is clearly important for the future of 'The College' that high quality examinations are retained as an effective mechanism by which the brightest and best are selected. The Irish College has conducted such examinations for some three hundred years. Though the fees gained may have been an important element in preserving the fabric and financial independence of the organisation, much more important is the fact that the examinations are the means of selecting those most able to be future Fellows of their College. Their vitality and excellence are critical if medical philanthropy is to curb a decision-making machinery at times remote. The voice of a Royal College can command attention just so long as it is an independent voice speaking for medical excellence.

In conclusion may I remind you that the opinions expressed this morning are exclusively my own and unlike "the evil that men do that lives after them", are "best interred with my bones".

#### THANKS

RCPI — The College Officers; The Examination Office; The Librarian.

RVH — Miss O'Prey, Dr Ian Bruce, Department of Medical Illustration.

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